(1)

Remarks Tracts 1421

ON

CHRONIC INTESTINAL STASIS

With Reference to Conditions Found at Operation and the Mortality.

DELIVERED AT THE NORTH-EAST LONDON POST-GRADUATE COLLEGE.

BY

WM. SEAMAN BAINBRIDGE, A.M., SC.D., M.D.,

PROFESSOR OF SURGERY, NEW YORK POLYCLINIC MEDICAL SCHOOL AND HOSPITAL;
SURGEON, NEW YORK SKIN AND CANCER HOSPITAL.

Reprinted from the BRITISH MEDICAL JOURNAL, *November 1st, 1913.*

LONDON:
PRINTED AT THE OFFICE OF THE BRITISH MEDICAL ASSOCIATION,
429, STRAND, W.C.

1913.

REMARKS

ON

CHRONIC INTESTINAL STASIS

WITH REFERENCE TO CONDITIONS FOUND AT OPERATION AND THE MORTALITY.

By Wm. SEAMAN BAINBRIDGE.

To Sir Arbuthnot Lane we are greatly indebted, for he has given to us a very clear view of the essential facts concerning stasis. He has evolved a most plausible theory as to its cause, and has pictured the far-reaching effects.

The cases he has presented are most convincing, especially so when we realize that they are not a small group of exceptions. We have seen seventeen patients to-day, many of them former human derelicts, now made over into useful and happy people.

During the past six years I have made five trips to England, and each time have studied the subject of chronic intestinal stasis. Every facility has been freely granted by Sir Arbuthnot for this work. Year after year I have seen his patients before operation, at the time of surgical treatment, witnessed his masterly technique, noted the history of the convalescent period, talked with staff and nurses and patients, and have seen a large number of the cases after an interval of many months.

Several times in the history of our profession Sir Arbuthnot Lane has blazed the trail into new fields, introducing radical methods of treatment, some of which have already become established as regular routine in surgical practice.

To aid this surgeon has come Dr. Jordan with his wonderful skill in *x*-ray diagnosis. Personally I have had many cases studied by very able men, but as yet we in America have not been able to equal his work. We are coming on, but Dr. Jordan is, I believe, to-day leading the way along this line.

With these two leaders here in London, with their work open to all, what can I add? However, a few facts from my personal experience may be of interest.

Intestinal stasis deserves our most serious consideration, and among the many questions which have naturally arisen in discussions of this subject, none is more important than the question of mortality.

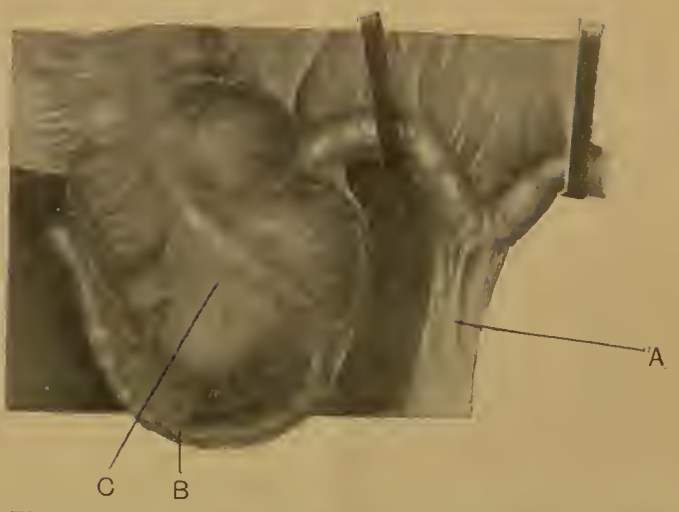

Fig. 1.—No. 14. A, Lane's band. B, Four-inch appendix adherent for 3 in. from tip to outer side of caput coli. C, Caecum mobile.

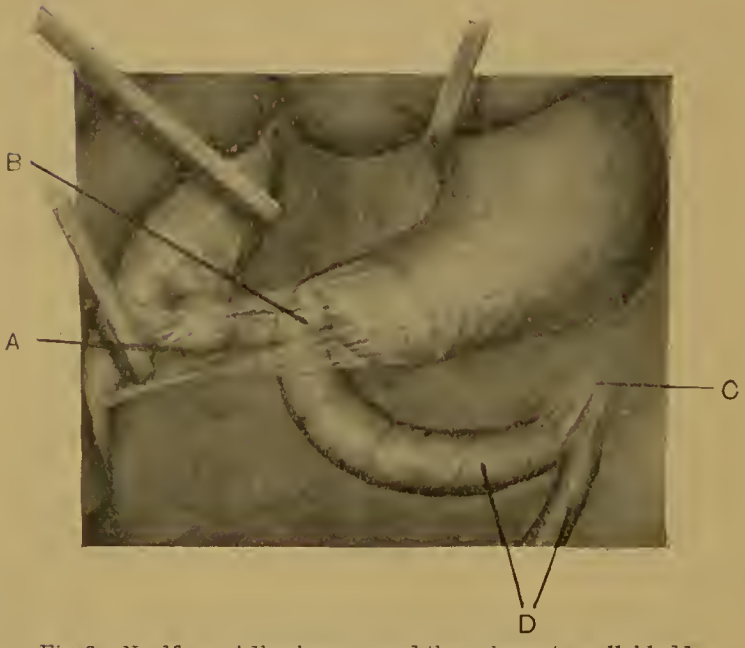

Fig. 2.—No. 16. A, Adhesions around the pylorus to gall bladder and liver. B, Pylorus angulated and narrowed. C, Kinking at duodeno-jejunal junction. D, Duodenum dilated aud jejunum collapsed.

Fig. 3.—No. 22. A, Lane's band. B, Dilatation of small intestine proximal to site of ileal kink. C, Jackson's membrane.

Fig. 4.—No. 26. A, Lane's band. B, Mobile caecum. C, Jackson's membrane.

Fig. 5,—No. 30, Ulcer of stomach. A, Dilated duodenum. Angulated duodeno-jejunal junction. B, Lane's kink. C, Prolapsed transverse colon. D, Jackson's membrane. E, Gastric dilatation.

Fig. 6,—No. 43. Ulcer of stomach. A, Dilated stomach extending below the umbilicus, due to cicatrized ulcer. B, Dilated duodenum. C, Duodeno-jejunal kink. D, Bands between gall bladder and pylorus.

Statistical Study.

I determined to investigate the statistics for myself, and have carefully collected the following, taking all cases operated upon by Sir Arbuthnot Lane from Martha Ward at Guy's Hospital from May, 1909, to October, 1913.

Operations.

Short-circuits 54
Removal of colon 52

Out of these—

2 cases of short-circuit were done for rheumatoid arthritis.
1 for trigeminal neuralgia.
1 for tuberculous hip.
3 short-circuit cases returned with a diverticulum.
3 cases of removal of the colon were done on patients suffering from exophthalmic goitre.
4 from rheumatoid arthritis.

After operations for removal of colon 5 cases returned suffering from adhesions and had further operations.

After short-circuit operation 8 patients returned and had removal of the colon.

Mortality.

1909. (i) A patient, aged 48, died after removal of colon ten days after the operation, from sepsis.

1909. (ii) A patient, aged 68, died of shock after removal of large intestine for advanced carcinoma of the caecum.

1910. (iii) A patient, aged 24, died of sepsis after removal of colon, ten days after operation.

1910. (iv) A child, aged 7, with advanced hip-joint disease, died of peritonitis three days after a short-circuit operation had been performed. Condition very bad.

1910. (v) A patient, aged 36, died in the theatre while a short-circuit operation was being done.

1911. No death.

1912. (vi) A patient, aged 20, who had a colectomy done in 1909 and did splendidly until December, 1911. In January, 1912, she returned with pain and vomiting; she was operated upon and found to be pregnant. Persistent vomiting for six days after operation, accompanied by acute pain. She aborted eight days after the operation, and died of general peritonitis the next day.

1912. (vii) A patient, aged 40, had removal of colon for advanced malignant growth; was almost moribund on admission; died a week after the operation, of exhaustion.

1913. (viii) A woman, aged 43, had removal of colon for rheumatoid arthritis; did splendidly; joints and muscles improved, and pain very much less; died of a pulmonary embolism ten days after operation.

To make the investigation a very searching one all deaths, from whatever causes, occurring in this ward after short-circuiting or colectomy are included. This is obviously unfair when considering the mortality of stasis. We must exclude at least the two malignant cases—the moribund child and the case of abortion with sepsis. Further, it must be noted that successful partial excisions

of the colon for growths are not included in our total list of cases. This leaves 54 cases of short-circuit, 52 of removal of the colon—106 in all. Four deaths—two from sepsis, one on the table, and one ten days after operation from pulmonary embolism. Thus the exaggerated statements of great mortality are not borne out.

Conditions Found at Operating.

There are some who are very sceptical as to the conditions found at the time of operation. In order to meet this and establish the facts, it has been my custom in my own practice often to have an artist present as well as a stenographer at the time of operation to record exactly the conditions found.

In order to have such evidence of record as true as possible, I selected an artist who knew nothing but normal conditions. The artist was directed to picture what she saw that differed from normality, with enough of the normal in the neighbourhood to make it clear as to what part was being represented. The stenographer took down a description of the operation at the time. Later, the finished picture on the one hand and the stenographer's description of the operation on the other, form a very important part of the records of the individual case.

In some of the pictures, a selection from which is published to illustrate this paper, clear evidence will be seen that the picture portrays the exact condition of the patient lying on the table, and not the condition which would be present when the patient is occupying a perpendicular position. This goes a long way to prove the honesty of the drawings.

To sum up, judging from the experience in Martha Ward at Guy's Hospital and in my own cases in New York, the mortality in operations for cases of intestinal stasis is astonishingly low. There is very little, if any, shock with the present technique; the much feared excessive thirst and persistent diarrhoea have not been borne out in our experience.

[In the captions of the pictures the names in common use for various bands have been employed. It should be understood that these are not looked upon by the writer as constituting in any way separate entities.]